Medical student attachments in private practice – The experience and views of the family practitioners

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Abstract

Background: Medical student attachments with family/general practitioners (GPs) in non-academic or private practice are a valued resource in the undergraduate teaching of Family Medicine. This study describes the experience and views of GPs in private practice with final-year medical student attachments from the University of Transkei.

Methods: A postal questionnaire was distributed to all GPs who had one or more student attachment.

Results: Out of 37 GPs, 25 replied, giving a response rate of 68%. Positive experiences of the attachments were enjoyment of teaching (n=24) and improvement in knowledge (n=20). Staff and patients' reaction to the students was felt to be positive overall. Negative aspects reported were finishing later at work (n=11) and patients leaving the practice (n=2). All GPs were willing to have students again and could take, on average, three students per annum. Twenty-one (84%) stated that a one-week's attachment was satisfactory. Eighteen (72%) were interested in teacher training. The majority (64%, n=14) did not require payment for teaching and 15 (60%) stated that they should be appointed as lecturers. Patients' consent to be seen by students was obtained by most GPs (n=13) when accompanied by the student. Out of 16 GPs who had students with Xhosa as their second language, eight assessed their language proficiency as poor.

Conclusions: The GPs in private practice that have medical student attachments enjoy teaching and their overall experience is positive. They feel their teaching commitment should be recognised by an academic appointment. Issues of patients' consent to examination and student language proficiency need further exploration.

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Introduction

Medical student attachments with family/general practitioners (GPs) in non-academic or private practice are an important teaching resource in Family Medicine.[1] At the University of Transkei (UNITRA), which is situated in Umtata, students in Family Medicine undertake ten weeks of clinical attachments in community-based primary care. The attachments used to be entirely in public sector health centres staffed by doctors in full-time governmental practice. However, since 2000, final year students spend one week of their attachment with a GP in private practice. This was a result of an initiative by the Umtata branch of the Academy of Family Practice/Primary Care (SAAFP), which recognised that, while the majority of GPs in South Africa are in private practice, students were not formally exposed to private practice.[2] Also, GPs in private practice are a teaching resource that can supplement the capacity of the Department of Family Medicine, especially in view of an increasing intake of medical students. This study describes the results of a questionnaire survey of the experience and views of the GPs in private practice who have had medical students attached.

Methods

Description of Student Attachment Programme

GPs were initially recruited from the membership of the SAAFP. As more GPs came into the programme, they themselves recruited colleagues. Some were recruited by medical students. All except one of their practices were in the Eastern Cape. The author was the coordinator between the GPs and the Department of Family Medicine. Students were divided into six groups (blocks) so that a group was sent for attachments at intervals of about six weeks throughout the academic year. Outside of Umtata, apart from a few students who stayed at their own homes, accommodation and board was provided at local hospitals or by the GPs. One student was assigned per GP from Monday to Friday. GPs were requested to use

problem-based learning. The problems or topics were those generated by the actual patients encountered by the student in the practice. GPs were also requested to allow students to consult on their own, as much as possible, and then to present the patient to the GP in a joint session. Students were encouraged to learn about practice management. Group practices had only one student attached per block and were thus counted as one GP. During their attachments, 61 (51%) students stayed in their own accommodation, 38 (32%) in hospitals and 21 (17%) were hosted by GPs in their homes or a guesthouse.

A postal questionnaire was sent to all GPs who had one or more students attached to his/her practice in the years 2000 to 2002. In group practices, the doctor most involved in student teaching completed the questionnaire. Information was requested on professional and practice characteristics, the impact of the student on the practice, the selection of patients for students, the teaching format, training needs, the doctors' overall experience of the attachments, and their views on academic status and remuneration. They were also requested to add comments or suggestions concerning any aspect of the programme.

Results

Out of 37 GPs who had one or more student attachments, 25 returned questionnaires, giving a response rate of 68%.

Characteristics of the respondents

See Table I. A postgraduate Diploma is a diploma awarded in any specialty. Postgraduate Family Medicine (Specialist) qualifications included M Fam Med, M Prax Med, MFGP (SA) or FRCGP.

Work outside private practice

Of the 25 doctors, eight (32%) had sessions in public sector hospitals or clinics, eight (32%) were district surgeons and three (12%) had academic teaching appointments.

Table I: Characteristics of the GPs and practices

Characteristic	No. (%)
Sex:	
Male	18 (72)
Female	7 (28)
Ages:	
20 – 29:	1 (4)
30 – 39	8 (32)
40 – 49	10 (40)
50 – 59	6 (24)
Years qualified:	
0 – 4	3 (12)
5 – 19	16 (64)
20 +	6 (24)
Postgraduade qualifications:	
Diploma	8 (32)
Family Medicine	5 (20)
Practice:	
Solo	20 (80)
Dispensing	25 (100)
Location in city/town	25 (100)

Practice premises, equipment and procedures

Twenty-two (88%) practices had a separate room for the student to consult in. Twenty-three (92%) had Internet access, 13 (52%) an ultrasound scan, and 18 (72%) an ECG machine. Twenty-two (88%) performed minor surgery, seven (28%) performed termination of pregnancy and three (12%) undertook deliveries.

Previous student attachments

Nine (36%) had students before this programme (and four took students from other universities).

Impact of students on practice

See Table II. The data are the doctors' subjective impressions.

Table II: Impact of student on practice

Aspect	Frequency (%)
• Finished work later (average 1.5 hrs)	11 (44)
• Income reduced (patients left)	2 (8)
• Patients' reaction	
– positive	16 (64)
– neutral	9 (36)
• Staff reaction	
– positive	19 (76)
– neutral	6 (24)

Selection of patients for students

Nineteen (76%) doctors excluded certain patients from consultations with students. Of the 11 who gave reasons, five stated confidentiality issues. Other categories were new patients and "problem" patients whom the GP knew would be uncomfortable with someone else. Also, 11 doctors reported that some patients (estimated at five per week) declined to be seen by students.

Patients' consent to be seen by student

See Table III. The majority of GPs, i.e. 13 (52%) requested the patients' consent when they were accompanied by the student.

Table III: Obtaining patients' consent to see student

Method	Frequency (%)
Doctor with student	13 (52)
Doctor alone	8 (32)
Receptionist	1 (4)
All of above	3 (12)

GPs' experience of the attachment

See Table IV. When asked "Did you enjoy student teaching", 24 stated "Yes" and one "Don't know". Eight stated that they had to read up on or revise topics as a result of interaction with the student, four said that discussion helped improve their knowledge or skills and 10 that they had learnt directly from the student. Examples of items learnt from the students included the realisation in one consultation of the importance of peer pressure in adolescent decision making; new disease management protocols; and using a urine dipstick to decide if a pleural effusion is a transudate or exudate. One student diagnosed aortic incompetence that the GP had missed.

Intention to continue teaching

All replied that they would take students again (although two who were leaving private practice would be unable to do so).

Table IV: GPs' experience of attachment

Aspect	Frequency (%)
Improved knowledge	20 (80)
Improved patient care	9 (36)
Improved clinical skills	9 (36)
Learning directly from student	10 (40)

Teaching format
All the GPs were happy with the problem-based learning approach. All except one GP allowed students to examine patients on their own. The GPs estimated that, on average, the students saw 46% of patients on their own and 64% while sitting in with the GP.

Training needs
Eighteen (72%) GPs expressed interest in a workshop to assist them to teach. Suggested topics were the provision of teaching materials, physical signs, communication skills and Internet skills.

Views on number and duration of attachments
When asked, "How many students could you take per annum", the average was three and the mode two. Twenty-one indicated that one week per student was acceptable.

Proficiency in Xhosa as a second language
When asked if students should be proficient in Xhosa as a second language, 15 replied "Yes", nine that "It doesn't matter" and one "No". Of 16 who had students with Xhosa as a second language, eight judged their proficiency to be poor and eight judged it to be adequate.

Continuing professional development points
Twenty-two GPs agreed that the allocation of 10 points (one point for one hour of educational activity) was adequate for the attachment. Three thought more should be allocated.

Academic status
Fifteen (60%) stated that GPs should be appointed as lecturers in Family Medicine.

Payment for teaching
When asked if they should be paid for teaching, out of 23 responses, 14 stated 'No' and nine stated 'Yes'.

Board and lodging
Of the six doctors who hosted students in their homes, none reported any interference in their social lives. All six were willing to host students again.

Comments and suggestions
Three GPs were unhappy about the students' sloppy dress. Two felt strongly that teaching students was a community duty for all GPs.

Discussion
Overall, the GPs were positive about teaching students and all were willing to continue teaching. The GPs' commitment to teaching is comparable to that reported in studies in Cape Town, Australia, New Zealand, the United Kingdom and the USA, where GPs in private or non-academic practices are an important resource for undergraduate teaching.[3,4,5,6,7] In a national survey of community-based family physicians in the USA, 30% taught, on average, three medical students for 10 days each.[7] In this study, GPs were prepared to take three students per annum for one week each. For most of the GPs, it was the first time that they had taught students. This suggests a general commitment and altruism among GPs towards teaching.

GPs enjoyed the teaching, with the majority reporting gains in their knowledge. The practice staff were also positive about the students. This is also the experience in other studies.[4,5] The benefits of teaching outweighed the disadvantages of extra hours worked and some patients booking out. As regards productivity when a student is present, studies in private practice settings that quantified patient visits and income have had differing results, with one showing a decrease and one showing no change.[8,9] It is possible that with more experience in teaching, doctors allow students to do procedures or consultations that offset the time used for teaching.

The GPs assessed that, overall, the patients' reactions to the students were positive. The fact that most GPs excluded some patients from student consultation undoubtedly contributed to this. Studies have shown that most patients are positive towards students and recognise that they have an important role in teaching students.[10,11] However, up to 6% want to see the doctor on their own and up to 30% want to be given advance notice of a student in the consulting room.[10,11] One third of respondents in the Israeli study stated that they would refuse to be examined by a student alone.[11] In this study, the patients' consent was obtained mainly by the GPs when accompanied by the student. While it is likely that the GPs wanted to show courtesy and give reassurance by introducing the student, it is possible that patients feel pressured by this approach.[12] The receptionist may be best placed to obtain consent.[3] Giving the patient a free choice to see the GP alone or with a student is also relevant to the issue of quality of patient care during teaching consultations. In one study, up to 10% of patients left the consultation without saying what they wanted to say and 30% found it difficult to talk about personal matters.[10] Further research should be done locally to canvas patients' views.

All but one doctor allowed students to consult patients on their own. The willingness of GPs to allow students to examine patients on their own is positive, as students find passive sitting in with the GP to be boring.[13] The GPs' views on the issue of students performing physical examinations were not solicited. However, it is important for GPs to formu-

late guidelines for students, as one study reported that up to 22% of patients would be troubled by a repeat physical examination and 42% would be uncomfortable if a student of the opposite sex examined an intimate body part.[11]

A majority of GPs felt that all students should be proficient in Xhosa, the first language of practically all people in the Transkei region. Many elderly patients have little knowledge of English. The Faculty of Health Sciences has recognised the need for Xhosa proficiency and students whose first language is not Xhosa now have to pass a mandatory fluency test at the end of their first year (Prof. K Mfenyana, personal communication).

In this study, GPs who provided accommodation and meals for students were located in small towns (population less than 20 000). This willingness by GPs to host students is evidenced in a study of rural Australian GPs, 60% of whom accommodated students in their homes.[4]

GPs expressed a need for training in teaching. The expressed needs and issues raised in this study will be addressed in workshops between the GPs and the Department of Family Medicine, UNITRA.

Most GPs were willing to teach without payment. This follows the trend in other countries. In the USA, only 9% of non-academic GPs reported being paid for teaching.[7] In Australia, only half of the doctors reported some form of payment and 42% of these felt it was only a token.[4] However, if GPs take on more teaching responsibilities, payment may become a pressing issue. In this study, the GPs felt that they should be appointed as lecturers in Family Medicine. This recognition of their contribution to undergraduate teaching is under consideration by UNITRA (Prof. K Mfenyana, personal communication).

Limitations of the study include the 68% response rate. Non-responders may not be as positive about teaching. However, for those who enjoy teaching, it is a fair representation of their views. The study dealt mainly with GPs' perceptions. Further studies should be done to obtain the views of patients and staff.

Conclusion

GPs in private practice that have medical student attachments enjoy teaching and their overall experience is positive. The majority is willing to teach without pay and undergo training as teachers. They feel this commitment should be recognised by granting them academic status. Issues of patient consent and the students' language proficiency need to be addressed by the GPs and the Department of Family Medicine.

Conflict of interest

None declared

References

1. Gjerde CL, Levy BT, Xakellis GC. Unique learning contributions of a family medicine preceptorship. *Fam Med* 1998;6:410-6.
2. Goudge J, Cornell J, McIntyre D, Mbatsha S. Private sector financing. In: Ntuli A, Suleman F, Barron P, McCoy D. South African Health Review 2001. Durban: Health Systems Trust; 2001.
3. Levenstein S. Student attachment to a general practice in Cape Town. *S Afr Med J* 1984;66:535-7.
4. Barritt A, Silagy C, Worley P, Watts R, Marley J, Gill D. Attitudes of rural general practitioners towards undergraduate medical student attachments. *Aust Fam Physician* 1997;26(Suppl 2):S87-S90.
5. Holden J, Pullon S. Trainee interns in general practices. *NZ Med J* 1997;110:377-9.
6. Gray J, Fine B. General practitioner teaching in the community: a study of their teaching experience and interest in undergraduate teaching in the future. *Br J Gen Pract* 1997;47(423):623-6.
7. Vinson DC, Paden C, Devera-Sales A, Marshall B, Waters EC. Teaching medical students in community-based practices: a national survey of generalist physicians. *J Fam Pract* 1997:45(6):482-4.
8. Kirz HL, Larsen C. Cost and benefit of medical student training to a health maintenance organization. *JAMA* 1986;256:734-9.
9. Fields SA, Toffler WL, Bledsoe NM. Impact of the presence of a third-year medical student on gross charges and patient volumes in 22 rural community practices. *Acad Med* 1994;69:S87-9.
10. O'Flynn N, Spencer J, Jones R. Does teaching during a general practice consultation affect patient care? *Br J Gen Pract* 1999;49:7-9.
11. Monnickendam SM, Vinker S, Zalewski S, Cohen O, Kitani E. Patients' attitudes toward the presence of medical students in family practice consultations. *IMAJ* 2001;3:903-6.
12. Devera-Sales A, Paden C, Vinson DC. What do family medicine patients think about medical students' participation in their health care? *Acad Med* 1999;74:550-2.
13. Schamroth AJ, Haines AP, Gallivan S. Medical student experience of London general practice teaching attachments. *Medical Education* 1990;24:354-8.